

Conclusions

Use of aliases by low-income and homeless men in hospitals is uncommon. Use of health card numbers and a linkage algebra using secondary identifiers can markedly increase the yield of hospital database linkages.

SPECIAL POPULATIONS I

Beyond Traditional Barriers to Obtaining Preventive Services for Children and Teens

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ABSTRACT**Objectives**

We aimed to obtain a population-based perspective on barriers to obtaining recommended and fully covered preventive services offered to Medicaid-insured members of an urban-based independent practice association, health maintenance organization. Despite numerous health plan programs to improve utilization of preventive services, participation has remained below state and national goals.

Methods

A mixed-methods (qualitative and quantitative techniques) study was designed to identify member-perceived barriers to use of preventive care services. A purposive sample of members who had been identified as low or nonutilizers of preventive services was used to recruit 110 member participants for focus groups. Content analysis of the transcripts was used to detect emerging themes identified as reasons for not obtaining the recommended child and teen preventive services. A telephone survey was developed from the content analysis and was administered to an additional 560 members. Exploratory factor analysis was employed to identify underlying factors within the survey items.

Results

Focus group participants stated they received their desired level and types of preventive services even though health plan data indicated otherwise. They viewed the responsibility of the health plan as limited to providing opportunities to access services; the choice and responsibility for use of preventive services are theirs. There was no evidence that participants would voluntarily seek to obtain services beyond those they find personally valuable. Exploratory factor analysis of telephone survey data identified six factors that met the retention criteria. The factors explained 45% of the variance in the data. The expected factors included clinic culture, quality of care, insurance confusion and difficulties, clinic access, and transportation. An additional factor, preventive care values, emerged to confirm the perspective initially detected in focus group transcripts.

Conclusions

It is necessary to re-examine the measures of accountability within health care. Current data collection and data sources fail to represent the utilization patterns of this population. They do not account for the role of the consumer in preventive health care decision making. We must identify the value of current benchmarks and designated accountability for utilization of preventive services when the purported beneficiaries do not perceive sufficient value

to offset the opportunity costs related to obtaining services. The results of this study illustrate the inconsistency among health care policy, consumer-perceived needs and values, and the demand for provider and system accountability.

Health Status of Aboriginal People in the Inner City of Vancouver, British Columbia, Canada

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ABSTRACT

Objectives

We investigated the health status of aboriginal patients attending an inner-city health clinic from 1997 to 2001.

Methods

An analysis was performed on the Microsoft Access database at the Vancouver Native Health Society Medical Clinic located in the downtown east side of Vancouver, British Columbia, Canada. Variables included age, gender, housing status, clinic visits, substance abuse, human immunodeficiency virus (HIV) infection, highly active antiretroviral therapy (HAART) for HIV-infected patients, diabetes mellitus, uses of influenza, hepatitis B virus (HBV) and pneumonia vaccines, and death. The Statistical Package for the Social Sciences (SPSS, 11.0) was used for data analysis. Independent samples *t* test, chi-square test, and life tables method and logistic regression analysis were adopted for mean values, bivariate and survival analyses, and identifying independent factors associated with death, respectively.

Results

Of a total of 11,442 patients who visited the clinic during 1997–2001, 36.0% (4,113) were Aboriginal people (2,194 males, 1,904 females, and 15 transsexuals).

Compared with non-Aboriginals, Aboriginals had higher HIV infection rate (10.3% vs. 6.4%, $P = .000$), incidence of diabetes (2.3% vs. 1.3%, $P = .000$), death rate (2.4% vs. 1.2%, $P = .000$), average clinic visits (8.5 vs. 6.4 visits, $P = .000$), influenza vaccine injection rate (7.1% vs. 5.4%, $P = .000$), and fixed address (86.3% vs. 83.9%, $P = .001$). There were no significant differences in substance abuse (33.9% vs. 32.5%), HAART for HIV-infected patients (25.3% vs. 29.5%), hepatitis B virus and pneumonia vaccines injections (2.9% vs. 3.2% and 0.5% vs. 0.4%, respectively) between Aboriginals and non-Aboriginals. Aboriginals had lower average age than non-Aboriginals (35.0 vs. 38.7 years, $P = .000$). The result of survival analysis showed the survival rate of Aboriginals was lower than for non-Aboriginals (mean score -57.56 vs. 32.30 , $P = .000$). The result of logistic regression indicated HIV infection ($P = .000$, odds ratio [OR] = 13.51, 95% confidence interval [CI] = 9.63, 18.96) and substance abuse ($P = .000$, OR = 2.42, 95% CI = 1.68, 3.49) were more likely to increase the death rate, while influenza vaccine injection would be a beneficial factor ($P = .000$, OR = 0.17, 95% CI = 0.07, 0.44).

Conclusions

Aboriginal people had higher incidences of HIV infection, diabetes, and death, but a lower survival rate than non-Aboriginals. Generally, Aboriginal people had worse health status. Education about substance abuse, HIV infection, and diabetes mellitus should be urgent tasks for decreasing the death rate and improving the health status of the Aboriginal people.

Challenges in Access to Care for Children With Mental and Physical Disabilities Under the Medicaid Program

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ABSTRACT

Objectives

Although one third of all disabled children and 7 of 10 poor disabled children in the United States receive their health insurance through Medicaid, little is known about their circumstances and access to care. A better understanding of the experiences of disabled children is needed to identify gaps under the current Medicaid program and to help policymakers as they develop Medicaid managed-care programs for disabled persons.

Methods

This paper examines differences in access, use, and satisfaction with care among children on Medicaid with physical disabilities, mental illness, and mental retardation/development disabilities (MR/DD). We used survey data obtained from the parents of a random sample of disabled children on Medicaid in New York City in 1999–2000 to conduct both descriptive and multivariate analyses.

Results

The Medicaid program in New York City has been successful at linking disabled children to health care providers: nearly all children have a usual source of care, and most have seen a provider in the past year. However, there is evidence of greater access problems under the Medicaid program for some subgroups of children, including those with mental illness and mobility impairments and those in fair or poor health.

Conclusions

Improving access for disabled children under the Medicaid program will require targeted help to specific groups of disabled children—for example, increased assistance with care coordination and management for children with mental disabilities and those in fair or poor health. Special assistance (such as help with transportation) could also be extended to children with mobility limitations. The study also revealed a need to increase the accessibility and availability of providers, a frequent problem under the Medicaid program.

KidCare Awareness Initiative: Understanding Barriers to Access for Underserved Children

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ABSTRACT

Objectives

The KidCare Awareness Initiative sought to identify barriers to the enrollment of eligible children in KidCare, the Children's Health Insurance Program in Illinois) and further define parents' perceptions of insurance as it relates to health care utilization and access to routine primary care.

Methods

We created an interview tool using forced choice and open-ended questions. Structured 20-minute interviews were conducted in Spanish or English with a convenience sample of 51 respondents in the waiting area of CommunityHealth Clinic, a free, volunteer-based clinic serving the uninsured in Chicago.

Results

We obtained 50 completed interview tools, representing 50 families and 97 children. The following were the findings: average age 34 years; 56% had a high school education or less; 74% were married/living together and 26% were single/divorced; 68% were Latino/foreign born (50% of these from Mexico), 20% were Latino/US born, 12% were non-Latino/US born; primary language of 82% was Spanish, and 18% spoke English; 35% were illegal (no papers), 29% were US born, 14% were naturalized, 12% had a tourist visa, 4% had a green card, 2% had a work visa, 4% provided no response; 84% were employed (one or more adults in family working full or part time); 67% of families earned less than \$20,000/year; there were an average of two children/family, and the children had a mean age of 7.2 years (range 1.2 months to 17 years); 56% of the families had fully insured children, 34% of the families had fully uninsured children, 14% had a mixture of insured and uninsured children (both insured and uninsured children due to mixed immigration status); 40% of the children were uninsured. There were 86% of the respondents who were familiar with KidCare, although 70% of these had not applied for it. As to reasons for not applying to KidCare (forced-choice answers), 70% thought their children were not eligible, 60% did not know what KidCare was, 40% were resistant to government help, 37% were worried about being treated differently or had immigration-related concerns, 37% were not interested, 30% thought it was not affordable, and 23% were resistant to changing doctors.

Conclusions

Despite availability of KidCare and respondents' familiarity with it, many do not access KidCare due to various socioeconomic, cultural, legal, and conceptual barriers. Conceptual barriers include not knowing how to utilize insurance benefits fully, in some cases not understanding what insurance is and how it is meant to improve one's health care access. We observed little difference in health care utilization (annual physical exams, annual emergency room visits) by the families with fully insured children versus those with fully uninsured children, demonstrating misunderstanding in health insurance utilization even among the insured.

Un-managed Care: the Mental Health of Canada's Inner-City Homeless

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ABSTRACT**Objectives**

One of the most enduring stereotypes of homelessness in Canada is that the majority of the homeless population suffers from some form of mental illness, and that one of the main causes of the problem itself is that it is the product of a widespread policy of deinstitutionalization from mental institutions that began in the 1960s. Despite this, the recent research literature suggests that, while this model has merit in explaining homeless in the 1960s and 1970s, there is little evidence for its validity in explaining homeless in the later two decades of the 20th century. The objective of this study therefore was to examine the mental health

and history of institutionalization/deinstitutionalization of a population of homeless men, women, and youths in a midsize Canadian city.

Methods

Using longitudinal data collected from a random stratified sample of the homeless in the western greater Toronto area (Mississauga, Brampton, and Caledon), we examined and now describe the psychological health of the homeless, as well as their history of institutionalization. In addition, we focus on their access to appropriate short- and long-term-care facilities as it is related to their homelessness. In this study, we contrast and compare the newly homeless with the chronically homeless, with a particular emphasis on men, women, youths, and older adults and their problems with access to mental health services and resources.

Results

Results from a series of logistic regression models, controlling for a variety of social and demographic characteristics of the homeless, indicate that the psychological and physical health problems of the chronically homeless significantly depart from those of the newly homeless, as well as across the key demographic groups identified above. The data reveal that those homeless who start from a more disadvantaged socioeconomic position are more likely to remain homeless for longer periods of time and to suffer from more extreme and chronic types of mental illness. Contrary to the conventional stereotype, both the chronically and newly homeless report that they are on the streets not because they have been deinstitutionalized, but because of a lack of mental health services, particularly managed- and supervised-care facilities.

Conclusions

The data presented demonstrate that deinstitutionalization is not a primary cause of homelessness per se. Rather, the correlation between mental illness and homelessness finds its roots in an absence of long-term managed-care facilities, particularly shelter/housing facilities, for those suffering from emotional, mental, and psychological health problems in Canada.

CANADIAN POPULATION HEALTH INITIATIVE

Predictors of Psychological Distress and Quality of Life in Disadvantaged Socioeconomic Populations of Montreal

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ABSTRACT

Objectives

Epidemiologic studies have shown that disadvantaged populations are more vulnerable to mental health problems. Socioeconomic level is considered to be the best predictor of mental health. According to the social vulnerability hypothesis, living conditions among the economically disadvantaged population are potentially more stressful; this in turn may increase susceptibility to psychiatric symptomatology. However, not all disadvantaged individ-